EDMUND G. BROWN JR.
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
KAREN L. GORDON
Deputy Attorney General
State Bar No. 137969
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2073
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GEETA SHERMAN** **4591 Sandburg Way** **Irvine, CA 92612** **Registered Nurse License No. 522200** Respondent.	Case No. 2011-564 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about May 23, 1996, the Board of Registered Nursing issued Registered Nurse License Number 522200 to Geeta Sherman (Respondent). The license was in full force and effect at all times relevant to the charges brought herein and will expire on December 30, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Business and Professions Code (Code) section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

8. Respondent was hired as a Registered Nurse at Fairview Developmental Center, Department of Developmental Services in Costa Mesa, California on or about July 19, 1999.

9. Respondent was assigned to care for developmentally disabled adult patients who reside in the Behavior Adjustment Program. The patients in this program present unique challenges due to their severe behaviors. Most require a highly structured environment.

10. On or about January 17, 2002, February 21, 2002, March 12, 2003, May 28, 2003, January 15, 2004, March 18, 2004, and July 30, 2004, Respondent received training specific to Managing Assaultive Behavior and the Prevention of Client Abuse, Clients' Rights, and Level 1 Incident Reporting, which included training on Fairview Policy and Procedures 1.5.2 Client Specific Rights, 1.6 Treatment of Clients, and 5.5.5 Incident and Client Injury Reporting.

11. On or about March 10, 1997, M.F. became a patient at Fairview Developmental Center. M.F. is a developmentally disabled male diagnosed with mild mental retardation and impulse control disorder.

12. On or about May 6, 2004, Respondent failed to intervene to protect developmentally disabled client M.F. from abuse. Respondent witnessed Senior Psychiatric Technician J.P. stand in front of M.F. in a threatening stance with his right hand pulled back and his hand in a closed fist, while two other staff members were restraining M.F. By not intervening, Respondent failed to maintain a safe therapeutic environment to ensure physical and emotional well being of patients/clients under her care.

13. Respondent failed to report client abuse in a timely manner. Instead of immediately reporting abuse that she observed, Respondent delayed and waited until the next day to report the abusive and intimidating actions to the appropriate authorities. The following day, on or about May 7, 2004, Respondent reported to her Program Director R.L that she witnessed Senior Psychiatric Technician J.P. hit or threaten to hit developmentally disabled client M.F on or about May 6, 2004 at approximately 6:35 a.m. Respondent was well aware of the requirement to immediately report abuse. As part of Respondent's training as a Registered Nurse employed at Fairview Developmental Center, Respondent attended numerous classes on prevention of client abuse and client rights which covered her responsibility to report suspected client abuse immediately to appropriate authorities.

14. Respondent was dishonest and provided misleading, inconsistent, and conflicting information to investigators regarding the abuse of M.F. Respondent was interviewed by investigators multiple times about the abuse of M.F. Respondent repeatedly changed her version of what she observed. Respondent reported to her Program Director R.L., that she witnessed Senior Psychiatric Technician J.P. strike M.F. with a closed fist in the abdomen, while M.F. was held by two other staff members. Then Respondent completed an Incident Report in which she altered her description and indicated that she saw two members holding M.F. while J.P. stood in front of M.F. in a threatening stance with his right hand pulled back in a fist, but J.P. did not strike M.F. Respondent told Unit Supervisor L.S. that she only had a brief glance at M.F. and J.P. and the hallway was very crowded with a lot going on.

15. As the investigation proceeded, the investigators obtained additional information which showed that the information provided by Respondent was inconsistent and misleading. Respondent gave five interviews in which she provided conflicting information, distorted or exaggerated information or lied, thereby misleading the investigators and causing a significant waste of valuable time. Respondent's conflicting statements confused the investigators and hindered the investigation of the alleged client abuse incident of May 6, 2004. Respondent violated Fairview Policy 6.6.12 Employee Conduct/Misconduct when she failed to furnish true and honest statements during the investigation.

16. On or about May 7, 2004, Respondent agreed that she would not discuss the confidential investigation. On or about August 26, 2004, Respondent admitted to Special Investigator J.H., that she violated the confidentiality by soliciting information regarding the investigation from Psychiatric Technician C.B. and by initiating a discussion regarding the investigation with Senior Psychiatric Technician J.P. Respondent's actions confused the investigation of the events of May 6, 2004 and violated Fairview Policies 1.3.1 Mission and Values and 6.6.12 Employee Conduct/Misconduct.

17. On or about September 6, 2004, Respondent advised developmentally disabled client M.F. that he had been assaulted by a staff member. Following her disclosure to the victim, Respondent told M.F. not to report the assault.

18. On or about September 9, 2004, Respondent admitted to Special Investigator J.H. that she violated developmentally disabled client M.F.'s right to report abuse when she dissuaded M.F. from calling the police or otherwise reporting the abuse. Respondent's actions violated Fairview Policies 1.5.2 Specific Rights, 1.6 Treatment of Consumers, and 5.5.5 Incident Reporting.

19. On or about September 9, 2004, Respondent was dishonest with Special Investigator J.H. by recanting previous statements regarding assaults by staff on developmentally disabled client M.F.

20. On or about September 30, 2004, Respondent admitted to Special Investigator J.H. that she failed to protect developmentally disabled client M.F. from Senior Psychiatric Technician J.P.'s abusive conduct.

21. On or about June 9, 2005, Fairview Developmental Center sent a Notice of Adverse Action to Respondent, indicating that she would be terminated from her position as a Registered Nurse with the Department of Developmental Services at Fairview Developmental Center on June 16, 2005 for inefficiency, inexcusable neglect of duty, dishonesty, discourteous treatment of the public or other employees, willful disobedience, and other failure of good behavior of such a nature that it causes discredit to the appointing authority or the person's employment.

22. Respondent appealed the Notice of Adverse Action to Dismiss her from her Registered Nurse position at Fairview Developmental Center, Case No. 05-2180.

23. The matter was settled and Respondent was suspended for 30 calendar days from her position as a Registered Nurse at Fairview Developmental Center. The charge of willful disobedience was removed from the action.

24. On or about October 19, 2005, the State Personnel Board adopted the stipulation for settlement as its decision in the matter, Case No. 05-2180.

25. On or about October 21, 2005, Respondent had training specific to Clients' Rights.

26. On or about March 28, 2006, Respondent had training specific to Prevention of Client Abuse.

27. On or about October 27, 2006, Respondent had training specific to Client Protection.

28. On or about November 12 and 13, 2006, Respondent was assigned as Acting Shift Lead.

29. On or about November 13, 2006, Unit Supervisor S.B. was unable to locate Respondent between 2:00 a.m. and 2:40 a.m. S.B. finally located Respondent asleep in an unoccupied bedroom. Respondent was sleeping while on duty during her assigned shift and was away from her developmentally disabled clients. Respondent admitted to S.B. that she started taking a rest at approximately 1:00 a.m. For approximately one hour and forty minutes, Respondent failed to maintain proper supervision of her developmentally disabled clients that were entrusted to her care. Respondent was only entitled to a 15 minute break. Respondent failed to remain alert during her assigned shift.

30. As charge nurse on or about November 13, 2006, Respondent would have been expected to be responsible for assigning staggered breaks of staff and enforcing 30 minute client checks for safety. Instead, Respondent allowed another staff member to also sleep while on duty. Respondent failed to assign breaks and enforce client safety checks.

31. Respondent falsified documentation and indicated that she was doing 30 minute patient welfare checks on or about November 13, 2006, when in fact, she was asleep for approximately one hour and forty minutes.

32. On or about November 14, 2006, a criminal report was filed by Costa Mesa Office of Protective Services Police against Respondent and two other nurses for dependent adult abuse and neglect in violation of Penal Code section 368(c), for failure to maintain proper supervision of developmentally disabled clients on November 13, 2006.

33. On or about March 8, 2007, Respondent was dishonest during her investigative interview when she contradicted her statement to S.B. that she began her break at 1:00 a.m. and stated to Investigator P.M. that she began her break at 1:45 a.m. Respondent also stated that she could hear everything that was going on in Residence 115 and checked on two clients who coughed.

34. On or about April 18, 2008, Fairview Developmental Center sent a Notice of Adverse Action to Respondent, indicating that she would be terminated from her position as a Registered

Nurse with the Department of Developmental Services at Fairview Developmental Center on April 24, 2008, for incompetency, inefficiency, inexcusable neglect of duty, dishonesty, and other failure of good behavior of such a nature that it causes discredit to the appointing authority or the person's employment.

35. On or about April 24, 2008, Fairview Developmental Center sent an Amended Notice of Adverse Action to Respondent making corrections of dates in two paragraphs in the Statement of Facts.

36. Respondent voluntarily resigned from state service, effective April 24, 2008.

37. On or about September 10, 2009, the State Personnel Board adopted the stipulation for settlement as it decision in the matter, Case No. 08-1892.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence for Failure to Intervene to Stop Abusive Behavior Toward Client)

38. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of gross negligence in carrying out nursing functions when she failed to intervene to stop abusive behavior toward developmentally disabled client M.F., as is more fully set forth in paragraphs 8 through 24, above.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence for Delay in Reporting Suspected Abuse to Authorities)

39. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of gross negligence in carrying out nursing functions when she failed to immediately report suspected client abuse, as is more fully set forth in paragraphs 8 through 24, above.

THIRD CAUSE FOR DISCIPLINE

(Incompetence in Discussions with Developmentally Disabled Client)

40. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of incompetence for advising developmentally disabled client M.F. that he had been assaulted by a staff member and then following the disclosure, advising M.F. not to report the assault, as is more fully set forth in paragraphs 8 through 24, above.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct for Providing Misleading and Conflicting Information to Investigators)

41. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct when she gave misleading and conflicting information to investigators regarding the alleged assault by staff of developmentally disabled client M.F, as is more fully set forth in paragraphs 8 through 24, above.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence for Neglecting her Developmentally Disabled Patients)

42. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of gross negligence for neglecting her developmentally disabled patients when she fell asleep while on duty as charge nurse, as is more fully set forth in paragraphs 8 through 11 and 25 through 37, above.

SIXTH CAUSE FOR DISCIPLINE

(Incompetence for Dishonesty and Falsifying Records)

43. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct when she was dishonest and falsified records by fraudulently initialing her name on the 24 hour Report Addendum indicating that she was checking on her clients every 15 to 30 minutes, when in fact she was asleep for approximately one hour and forty minutes during her shift, as is more fully set forth in paragraphs 8 through 11 and 25 through 37, above.

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SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct for Providing Misleading and Conflicting Information to Investigators)

44. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct when she gave misleading and conflicting information to investigators regarding falling asleep and neglecting her assigned developmentally disabled patients while Acting Shift Lead, as is more fully set forth in paragraphs 8 through 11 and 25 through 37, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 522200 issued to Geeta Sherman.

2. Ordering Geeta Sherman to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/22/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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